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Youth problems in the light of educational conditions. Physiological symptoms as a derivative of attachment disorders and tendencies to self-destructive behaviour

Problemy młodzieży w świetle uwarunkowań wychowawczych. Objawy fizjologiczne jako pochodna zaburzeń więzi i tendencji do zachowań autoagresywnych

Abstract. Conceptualisation in cognitive behavioural psychotherapy describes and explains the problems reported by the patient. The patient has specific beliefs about the world, others and themselves. Understanding the patient's psychological construct and beliefs requires exploring the environmental influences they experienced during early childhood. The first ten years of a young person's life significantly impact the subsequent development of personality and the adoption of specific social roles. When the patient gets to their roots, they begin to confront past events and try to work through them mentally so that they can later pursue their life goals without psychological burden. A key stage is building the parent-child bond and acquiring experiences. This article discusses attachment styles in young people and the problems they may encounter due to inadequate family upbringing. This paper is for illustrative purposes. Reference will be made to John Bowlby's Attachment Theory and Mary Ainswort's attachment research. Self-harm will be addressed based on the latest data from the American Psychiatric Association's classification of mental disorders.

Keywords: attachment, depression, psychosomatics, self-destructive behaviour

Streszczenie. Konceptualizacja w psychoterapii poznawczo behawioralne opisuje i wyjaśnia zgłoszone przez pacjenta problemy. Pacjent przychodzi z określonymi przekonaniami o świecie, innych ludziach i samym sobie. Zrozumienie konstruktu psychologicznego pacjenta, jego zbioru przekonań wymaga zapoznania się z oddziaływaniami środowiskowymi pacjenta w okresie wczesnego dzieciństwa. Pierwsze 10 lat życia młodego człowieka odciska się dość mocno na późniejszym kształtowaniu się osobo-

wości i przyjmowaniu określonych ról społecznych. Pacjent kiedy dociera do swoich korzeni, zaczyna konfrontować się ze zdarzeniami z przeszłości, próbuje je przepracować mentalnie, aby potem bez obciążenia psychicznego realizować swoje cele życiowe. Kluczowym etapem jest budowanie więzi rodzic – dziecko, oraz nabytych doświadczeń. Artykuł odnosić się będzie do stylów przywiązania u młodych osób i problemów na jakie może natrafić w związku z nieadekwatnymi formami wychowania w rodzinie. Niniejsza praca ma charakter poglądowy. Odnosić będzie się do Teorii przywiązania Bowlby'ego i badań nad przywiązaniem Mary Ainswort. Poruszona zostanie problematyka samookaleczeń w oparciu o najnowsze dane zawarte w klasyfikacji zaburzeń psychicznych Amerykańskiego Towarzystwa Psychiatrycznego.

Słowa kluczowe: przywiązanie, depresja, psychosomatyka, zachowania autodestrukcyjne

Introduction

From professional practice and observation of children and adolescents attending therapy, self-harm is a prevalent theme. This is one form of emotion regulation; pain gives them psychological relief and other benefits follow. Nowadays, young people are starting to seek psychiatric care more readily and are willing to be hospitalised. There is a new wave of problems facing not only psychologists and teachers but also parents of these children. The most common reasons for such behaviour reported by the youth are lowered mood, lack of meaning in life, unmet expectations, learning problems, peer influence on their well-being, and trouble forming their identity. You can sometimes hear the comments: "I'm not like other people", "I don't like myself", "I don't always cope well, self-harm helps me", "I'm original", and "No one experiences things the way I do". Some of these comments sound depressive, and some stem from the need for attention, to experience attentiveness from those close by. To a large extent, the causes of young people's problems originate in childhood. This is when a parent-child attachment is formed, and if it is insufficient, it results in deficits in dealing with emotions. This, in turn, leads to disorders in the formation of intimate and social relationships in adulthood. Although an individual's personality depends on many factors, attachment theory is one of the key factors in forming a correct psychosocial construct of the

individual. To help the patient, psychotherapy looks at the past, going back to the roots to work through the aspects of life that have caused the maladaptive style of functioning.

Attachment models

1. John Bowlby's Attachment Theory

Ethological research had a decisive influence on the emergence and shape of attachment theory. It proved that the offspring of certain animal species can develop a strong bond towards a particular figure acting as a mother without the mediation of hunger satisfaction. Particularly important were the ethological studies by Harry Harlow and Konrad Lorenz.11 Harlow experimented with young rhesus monkeys. They were given two dummies: one made of wire with a milk bottle attached and the other covered with a soft and woolly material. The monkeys strongly preferred the "soft and woolly" mother. They cuddled up to it and spent, on average, about fifteen hours a day with it, as they would have with their real mother. The monkeys spent an average of only about one hour beside the wire mother despite being fed by it. This rudimentary form of association: "soft-means-mother", is a factor in forming an emotional bond with the mother.

Bowlby argued that a biologically conditioned attachment system exists in every human being and is an integral part of human nature. The existence of this system explains the human tendency to form strong emotional bonds with other people and also sheds light on the aetiology of various psychological disorders. This thesis has become a central tenet of attachment theory.

2. Continuity of attachment throughout human life, according to Bowlby

With normal development, attachment behaviour leads to an emotional bond between the child and mother and between the child and other close family members.

Internal operational models of attachment are formed through experiences with people to whom the child is attached. This process takes place during the first developmental stages. The essential function of internal working models is to predict the behaviour of those to whom one is attached, particularly their availability and readiness to assist and protect when approached for assistance. If childhood experiences of interacting with people to whom children are attached are overwhelmingly positive, i.e. if these people are available and ready to respond to the child's needs, then the child develops internal working models incorporating positive beliefs about attachment figures and positive beliefs about themselves as people worthy of acceptance by others. On the other hand, if the child's experience of interacting with attachment figures is negative, that is, if these figures are not readily available and do not express a readiness to help and care for the child in situations where the child feels fear, insecurity, etc., then the child develops internal working models incorporating negative beliefs about attachment figures as unpredictable and untrustworthy and a self-image of someone unworthy of acceptance. These beliefs are then generalised to relationships with all other people: "An unwanted child is likely not only to feel unwanted by his parents but to believe that he is essentially unwantable, namely unwanted by anyone. Conversely, a much-loved child may grow up to be not only confident of his parents' affection but confident that everyone else will find him lovable too." The main stages of attachment include attachment in childhood. Bowlby proposes that the first year of a child's life represents the sensitive period in which attachment behaviour develops most readily. The author then goes on to identify attachment at the preschool age – as the child's cognitive abilities develop, the child slowly begins to empathise with the mother's different kinds of sensations and motivations. This leads to the formation of a partnership between them, a reciprocal relationship determined by a goal. At younger school age, the child's attachment creates a sense of security, derived from the conviction that the child can contact their parents or other attachment figures at any time, and these persons are available and ready to help if needed. Adolescence is when attachment to parents is loosened. In many stressful situations, adolescents avoid parental support and learn to cope with their problems independently.

It can be said that young people explore emotional independence from their parents because they know they can always expect help and support from them in a crisis. Every adult is involved in numerous interpersonal relationships of varying importance, some of which are close emotional bonds. Some of these can be described as attachments because they give the person a sense of security. It appears that in most cultures, this bond still exists, with parents still showing care and support towards their adult children even when they have already started their own family.[1]

As we can see, the emotional bond and attachment formed between parent and child during early childhood bear fruit and continue throughout a young person's life, influencing how they function and build social relationships.

3. Attachment according to Mary Ainsworth

Strange Situation Procedure (SSP) allows an assessment of infants' attachment to their mothers to be observed.

SSP consists of a 20-minute observation of children (aged between 12 and 18 months) first in a situation with their mother and then during two 3-minute separations, during which the mother leaves the room, and the baby is left with a stranger. This enabled the researcher to identify two categories of attachment behaviour.

Secure attachment: the child treats the caregiver as a secure base for exploration and a source of comfort in situations of perceived discomfort. The child is unquestionably aware of their absence upon separation. When the caregiver returns, the child greets the caregiver with a smile, draws near, gesticulates or vocalises, and seeks contact in a situation of perceived discomfort. The contact is mutually comfortable, and the child is able to return to play.

Insecure attachment: divided into anxious-avoidant, where the child seems more interested in the environment than the caregiver during the strange situation procedure. The very moment of separation from the caregiver does not provoke protest. When the caregiver returns,

[1] T. Srebnicki, Zaburzenia przywiązania [in] M. Janas – Kozik, T. Wolańczyk Psychiatria dzieci i młodzieży, vol. 2, PZWL, Warszawa 2021, pp. 3–7.

the child ignores them or actively avoids contact. Anxious-ambivalent/resistant attachment involves the child preferring contact with the caregiver more than exploring the environment. In a separation situation, the child shows clear signs of distress. When the caregiver returns, the child shows anger towards them or cannot calm down. Disorganised/disoriented attachment: the child's behaviour lacks an organised and coherent strategy in the relationship with the caregiver.

Following Mary Ainsworth's research, Agnieszka Stein describes these three attachment models in social functioning and emotional coping. The first avoidant attachment style results from repeated, consistent experiences in which the child gets the message that they should deal with their emotions and not bother others with them. A person with an avoidant attachment style experiences emotions and stresses, but instead of understanding these emotions and making peace with them, they suppress and repress them. Often, they cannot even say what they are feeling, or they feel anger instead of any emotion. They generally consider all emotions to be bad and troublesome. They fail to cope with difficult emotions and fully experience pleasant ones. Sometimes, they suppress emotions very strongly, finally losing their composure and exploding, hurting others. Such a person avoids closeness.

The second anxious attachment style results from the interaction between the child's predisposition and adult behaviour. On the child's part, it is an extreme sensitivity to the stimuli around them and difficulties with self-regulation. On the adult's part, it is chaotic and inconsistent childcare with incomprehensible rules. Inconsistent care means that when a child communicates a need, they are sometimes supported and other times not, which happens according to rules that the child cannot discern or understand at that stage. Children with an anxious attachment pattern often tend to exaggerate their behaviour. They exaggerate their emotions and needs. Sometimes, their behaviour is theatrical, and they receive the label of manipulators and coercers. Often, children with anxious attachment are considered spoilt, coddled and not given boundaries. They communicate their needs openly and directly. They do not pretend to be cheerful when they are sad, and they do not manifest their needs through illness or other problems (they

do not say: "My stomach hurts" when they want a hug). A child with a secure attachment style knows and feels that they can try to cope with all sorts of challenges, and if they find it difficult, they can always ask for help and will be taken seriously. They know that they are important and needed. They can manage the tension in difficult moments enough to feel and understand what they are feeling and why.

The child is not afraid to communicate their emotions to others. They are not afraid of rejection when others find out how they really are and what they feel. They are also not afraid to be close to someone experiencing difficult emotions.[2]

Attachment disorders as a diagnosis are included in the DSM-5 under trauma- and stressor-related disorders. Two types of attachment disorder are listed. The first is reactive attachment disorder, which is characterised by extreme withdrawal, lack of a clearly defined attachment figure, no tendency to seek comfort from others in situations of discomfort, and lack of reciprocity and reactivity in social contacts. The second one – disinhibited social engagement disorder – involves excessive ease in establishing social relationships; this is manifested by the atypical establishment of social relationships characterised by actively approaching and making contact with strangers due to reduced or absent wariness to approach them, making contact inconsistent with cultural and age norms; exaggerated friendliness or verbal contact; reduced or absent need to look back when going away with a stranger or willingness to go away with a stranger with little or no hesitation.[3]

Considering certain attachment deficits in the case of an anxious-ambivalent style of functioning in childhood, such a person is much more likely to develop a borderline personality – one that is emotionally unstable or dependent – in adulthood. In contrast, an avoidant attachment style will be typical of people with an avoidant or paranoid personality.[4]

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[2] A. Stein https://dziecisawazne.pl/style-przywiazania/

[3] T. Srebnicki, Zaburzenia przywiązania [in] M. Janas – Kozik, T. Wolańczyk Psychiatria dzieci i młodzieży, vol. 2 PZWL, Warszawa 2021, pp. 3–7.

[4] M.E.P. Seligman, E. . Walker, D.L. Rosenhan Psychopatologia ZYSK i S-Ka 2003

Emotional problems of adolescents

Lack of appropriate attachment patterns in adolescents causes emotional conflicts, depression, behavioural and emotional disorders, and a lack of control over internal impulses. Some individuals experience anger at the injustices they face in secret, driving them to a mental breakdown. There are also people who cry, panic, make uncontrollable movements or are unable to control their behaviour in the face of difficulties. In both cases, these individuals are experiencing a strong emotional charge that they cannot cope with. Due to their lack of emotional regulation skills, they resort to self-centred behaviour. It should also be noted that these people often suffer from various somatic complaints. They complain of frequent migraines, gastrointestinal problems, endocrinological issues and the like, which are not strictly medical but rather stem from psychological factors. The burden of stressful situations and the lack of adequate support and appropriate family ties mean that unwanted stimuli constantly affect the autonomic nervous system. Therefore, panic attacks are often accompanied by dizziness, a feeling of warmth, sweating and an accelerated heartbeat; in introverted individuals, migraines, skin lesions and abdominal pain are more likely to be observed. A common feature of these two types of attachment is a more frequent tendency to self-destructive behaviour, such as self-harm or self-inflicted pain, with suicidal thoughts or tendencies sometimes emerging. Psychiatric and psychological communities are seeking to explain self-harm. The DSM-5 classifies it as a nonsuicidal self-injury (NSSI).

The DSM-5 identifies two leading psychological theories based on functional behavioural analyses. One sees NSSI as a form of self-punishment by taking responsibility for unpleasant experiences in life. The second theory relies on the learning of behaviour through the experience of relief after self-harm, getting the attention of a significant person or negative reinforcements linked to affect regulation by reducing, for example, suicidal thoughts. In some teenagers, self-harm is paradoxically seen as a way of postponing suicide – a protective measure by reducing negative emotions (for example, self-criticism)

At times, harming oneself is a functioning style or even some part of one's identity. You can hear the comments: "It's just how I am; it's my

way of dealing with problems," "I wasn't supposed to do it, but I don't know how else to cope," or "I lasted 50 days, but a problem arose, and I started self-harming again". The severity of wounds can range from the smallest scratches to ones needing surgical stitches. The latter represent an act bordering on a suicide attempt.

At school, such children are either socially withdrawn or create a lot of problems. Such pupils worry teachers, who who appear powerless to help them with their problems. It is important to consider that the school is there to educate, not to solve pupils' mental problems. Children's emotional problems have escalated so much in recent years that it is incumbent on every school to provide psychological support. Helping the pupil in crisis is extremely important. Self-harm occurs when the emotional component is triggered, as we know. We hear about sadness, anxiety, stress. These emotions create tension in the body and trigger somatic problems, such as headaches, stomach aches, neuralgia, metabolic problems, and, in extreme cases, various types of illness.

In Nock's integrated theoretical model of NSSI, the interrelationships between distal risk factors – genetic predisposition to strong emotional and cognitive reactivity, childhood exposure to sexual abuse, domestic violence, family hostility and excessive criticism—are important.

Hence, many factors can influence a child's attitude. These can be divided into intrapsychic vulnerability – strong negative emotions and cognitive distortions (others are hostile to me) – intolerance of psychological discomfort (low frustration threshold), and interpersonal vulnerability – deficits in communication skills and poor skills in solving social problems.

Self-harm has a regulatory function in the model described above in relation to social situations and emotions experienced. This regulatory conception of NSSI is supported by the hypotheses of social learning, self-punishment, social signalling, analgetic action and unconscious identification. An important mechanism leading to adolescent self-harm is the social contagion effect of the desire to be noticed—pay attention to me; to punish someone – see what you made me do; to make a significant figure withdraw – Maybe now you'll leave me alone; to coerce – If you don't do, it I'll cut myself; and to compete for caring individuals, to expect aversive consequences – If I hurt someone, I'll

go to jail; if I cut myself, there will be no punishment. NSSI occurs as a result of observing it in others.

The skill deficiencies described affect the response to stressful situations, either by excessive arousal, less frequently a lack of reactivity, or by presenting an inability to respect social imperatives.[5]

Summary and conclusions

The study of childhood attachment may explain the inadequate behaviour of adolescents in their teenage years. The initial family transmits certain patterns of relationships and shapes the child's attitudes and beliefs about themselves and others. Core beliefs represent the deepest level of cognition and are global, rigid and generalised. According to Beck, they are almost synonymous with cognitive schemas. They concern ourselves, other people and the world. Most core beliefs develop in childhood, but some may arise later, especially due to traumatic events or significant life changes.[6] Bringing up young people in secure attachment conditions offsets coping problems in everyday life. Such a young person is able to act independently, but they also have close people who make them feel accepted and can always count on their help. They are strong, but this strength is inside them. It does not hinder them from interacting with others but allows them to act independently.[7] People with disturbed attachment patterns are much more likely to assume that the world is dangerous, that people are unfair and unaccepting, and their sense of worth is impaired. A feeling of insecurity about one's situation, loneliness, the need to prove to others that one is strong, or the constant search for acceptance by loved ones results in a lack of a stable sense of self, i.e. a properly

[5] A. Gmitrowicz Samouszkodzenia i samobójstwa w populacji [in] M. Janas-Kozik, T. Wolańczyk, Psychiatria dzieci i młodzieży, vol. 1 PZWL, Warszawa 2021, pp. 493–506

[6] M. Skowrońska, Cognitive-behavioural therapy for chronic pain vol. 15 1/2011; [https://www.termedia.pl/-Cognitive-behavioural-therapy-for-chronic-pain-,63,18170,1,1.html]

[7] A. Stein https://dziecisawazne.pl/style-przywiazania/

formed personality. As a result, self-destructive behaviour emerges. The DSM-5 classification includes a diagnosis of suicidal behaviour disorder, which requires further study.

The problem of self-harm sometimes runs so deep that it comes to encompass thought and behaviour. Ir represents a way of dealing with problems, which is difficult to change through therapy. It can be likened to an addiction to the sensations derived from it; a sense of relief is desirable when mental suffering interferes with normal functioning. Intentional self-harm is a deliberate self-injury without suicidal intent; it is unlikely to be life-threatening. It is not socially acceptable behaviour, unlike body piercing or tattoos. According to a 2014 WHO report, self-harm without suicidal intent can nevertheless result in a fatal outcome classified as suicide.[8] Therefore, mental health prevention in young people is important to counteract self-destructive tendencies. Systemic therapy, which involves the participation of the parents and the child, would help to repair inadequate attachment patterns. It is grounded in emotional fusion, where the emotional bond with a system member is so strong that it is unclear whether they are experiencing their own emotions or, in fact, the emotions of just one person in the system. Morphogenesis is the attempt to persuade a family to change its functioning. Triangulation involves reducing tension between two system members by working together to solve another system member's problems. Morphostasis is the ability of a system to maintain its constancy.[9] On the other hand, when parents do not agree to such therapy, another solution is individual therapy for the child/young person and work on their values and belief system. These interventions aim to reduce self-harming tendencies by strengthening self-esteem, practising ways of dealing with emotions and introducing interpersonal training to build correct social bonds.

[8] A. Gmitrowicz Samouszkodzenia i samobójstwa w populacji [w] M. Janas – Kozik, T. Wolańczyk, Psychiatria dzieci i młodzieży, vol. 1, PZWL, Warszawa 2021, pp. 493–506.

[9] T. Nęcki Terapia systemowa: na czym polega i jakie rozwiązania wykorzystuje? (2017)https://www.poradnikzdrowie.pl/psychologia/zdrowie-psychiczne/terapia-systemowa-na-czym-polega-i-jakie-rozwiazania-wykorzystuje-aa-gVPx-QA1q-cvF7.html

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